

PLEASE NOTE: The individual to whom this is addressed is to confirm receipt to sender.

Attached is a copy of the results from the State Licensure Compliance Inspection and/or Focus Inspection recently completed at your facility. Open and review the attached PDF form of the Report.

Please respond to the ALF Inspection Report by:

1. Use the attached "ALF Provider SOC" for providing a response to the violations. Please do not change the formatting of the document including the margins and column sizes.
2. Type each regulation number for the violation cited in the column labeled "Regulation".
3. Type your Statement of Compliance (SOC) in the column labeled "Providers Statement of Compliance". You can continue to type as the text will wrap around the cell so that you are not limited in your response. The SOC for each violation will have three elements that must be completed. The elements are:

A. STEPS TAKEN TO CORRECT VIOLATION (SYSTEM CHANGE):

B. ESTIMATED TIME TO CORRECT (COMPLETION DATE):

C. JOB TITLE OF THE PERSON RESPONSIBLE FOR CORRECTION

4. The space for two SOC's is provided. If you have additional violations, please copy and paste each element stated above. The space is unlimited.
5. If you lock the ALF provider SOC form, please leave the "Office Use Only" area unlocked.
6. Print off the entire ALF Inspection Report form and your completed "ALF Provider SOC" for your records. Post the ALF Inspection Report and the ALF Provider SOC in your facility as per regulatory requirements.
7. Attach the completed ALF Provider SOC in an email and send to dhhs.healthcarefacilities@nebraska.gov within 10 days of receipt of this email.

Your opinion is important to us and we would like your feedback. Please complete an evaluation about this survey by clicking on the link below:

http://dhhs.ne.gov/publichealth/Pages/crl_facindex1.aspx

The completed SOC's should look like the following:

ASSISTED LIVING FACILITY STATEMENT OF COMPLIANCE

PROVIDER NAME:	ABC ASSISTED LIVING
STREET ADDRESS, CITY, ZIP:	123 Anywhere Street, Lincoln 68512
PROVIDER LICENSE NUMBER:	ALF999
SURVEY DATE:	October 1, 2014

REGULATION	PROVIDER'S STATEMENT OF COMPLIANCE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE VIOLATION)
4-006.02	A. STEPS TAKEN TO CORRECT VIOLATION (SYSTEM CHANGE):
	Please type your system change here. This text will wrap around so if you keep typing it will automatically go to the next line.
	B. ESTIMATED TIME TO CORRECT (COMPLETION DATE):
	Respond to this area also.
	C. PERSON RESPONSIBLE FOR CORRECTION:
	Respond to this area also. Do not use staff names in this area.
4-006.13B	A. STEPS TAKEN TO CORRECT VIOLATION (SYSTEM CHANGE):
	Please type your system change here. This text will wrap around so if you keep typing it will automatically go to the next line.
	B. ESTIMATED TIME TO CORRECT (COMPLETION DATE):
	Respond to this area also.
	C. PERSON RESPONSIBLE FOR CORRECTION:
	Respond to this area also. Do not use staff names in this area.
	Office Use ONLY: Accepted by: _____ Date: _____
	Onsite Needed: Yes _____ No _____